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THE MENTAL HEALTH OF LOW SOCIO-ECONOMIC POPULATIONS

A Thesis

Submitted

in Partial Fulfillment

of the Requirements for the Designation

University Honors with Distinction

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Abstract

Depression is an illness that has a negative impact on our society. Depression not only lowers the depressed person's quality of life, but it also negatively impacts people close to the person suffering from this illness. This research is in response to the seriousness of this epidemic, particularly in the low socio-economic status (low SES) population. Topics explored include factors of a low SES environment that influence the onset of depression as well as how those factors relate to the quality of mental health care among depressed people of low SES. A review of the literature identified many barriers to depression treatment in a low SES population, and several depression treatments that attempt to overcome these unique barriers were compared and evaluated.

The mental health of low socio-economic populations

Depression is an illness that has a negative impact on our society. On the individual level, depression hurts many aspects of one's life, including emotional health, physical health, and the ability to enjoy life (Sullivan, 2003). Depression not only lowers an individual's quality of life, but it also negatively impacts people who interact with the depressed person. The psychological symptoms of depression can be accompanied by somatic symptoms such as fatigue, which makes it difficult for a person suffering from depression to function in a work setting (Hung & Chung, 2001; Abrams & Curran, 2007). This means people who are already economically disadvantaged have their poor financial status reinforced. In addition to the consequences on the micro level, depression weighs down the economy. According to the World Health Organization (2001), global productivity will receive the most financial strain from mental disorders by the year 2015.

This research is in response to the seriousness of this epidemic, particularly in the low socio-economic status (low SES) population. Thus, the purpose of this research is to explore the relationship between mental health and low SES. Topics explored include factors of a low SES environment that influence the onset of depression, as well as how those factors relate to the quality of mental health care among depressed people of low SES. This research includes a review of existing programs designed to improve mental health care, both for the prevention and treatment of psychological maladjustments. As a result of these interests, the following research question is addressed: What is the relationship between depression, low socio-economic status, and community psychology?

Three central themes have been identified for this research. The first theme is that a strong relationship exists between low SES and depression. This relationship is expected to be a positive one; a high level of poverty should be correlated with a high depression rate.

The second theme is that factors related to living in a low SES environment contribute to a decreased quality in mental health care. This theme goes beyond the assumption that having a lack of financial resources contributes to the onset of psychological maladjustment. Instead, the theme focuses on the variables that may influence the poverty-depression link. The literature is expected to confirm that living in a low SES area influences mental health and that mental health care in a low SES area is deficient as well as hard to access.

Finally, the third theme is that community psychology can provide solutions to the problem of poor mental health among people in low SES. In this research community psychology refers to community programs designed to prevent the development of depression. A hope for this research is to identify proposed solutions to the problem of depression among people in low SES. Further, programs with empirical strength will be identified that can effectively provide mental health care for the prevention and treatment of depression.

Methodology

A review of the literature was performed on variables of low socioeconomic status, depression, and depression treatment. Information was accessed from multiple databases through the University of Northern Iowa Panther Prowler. Most studies in the review emphasized the special issues of depression in a low socio-economic population, but literature was not limited to this specific criteria. All studies included an aspect of depression, low SES, depression treatment, or barriers to depression treatment relevant to the research questions.

The first step in the literature review was the collection of data; articles related to low SES and depression were examined, and as data were gathered the search became more refined to reflect the scope of the research questions. After gathering and reviewing an extensive compilation of literature, the studies were analyzed to identify empirically supported data on the relationship between poverty and depression as well as depression treatments that were effective in meeting the needs of a low socio-economic population.

Literature Review (Results)

Depression and Low SES

The literature shows strong support that low SES significantly increases the risk of depression. Low SES doubles the risk of developing major depression, and there is a correlation between family income and depressive symptoms in children (Bruce, Takeuchi, & Leaf, 1991; Tracy, Zimmerman, Galea, McCauley, & Stoep, 2008). In a study by Areán, Gum, Tang, and Unützer (2007), poor participants were more likely at the baseline to suffer from major depressive disorder and to have had past episodes of depression. These participants were also more likely to have co-morbidities such as anxiety or cognitive problems.

Although there is agreement that low SES and depression are closely linked, the reasons behind this relationship remain debated and unclear. It is hard to determine the exact causal factors due to the complex nature of the interaction between low SES and depression. There are many risk factors associated with income status, and it is difficult to separate them to determine if any of the proxy risk factors of income status directly cause depression. Tracy, et al. (2008) obtained information on income status as well as the number of significant life events, divorced or separated parents, level of parental support, aggregate SES of the neighborhood, level of violence in the neighborhood, and race/ethnicity. A correlation was found between depressive

symptoms and all of these factors, and after controlling for other risk factors, only 45% of the effect size of low family income on depressive symptoms remained when controlled for all other risk factors (Tracy et al., 2008).

There is a lot of literature available on geographic area, low SES, and mental illness. The author of *Community Psychology: Challenges, Controversies, and Emerging Consensus* discusses how location can have an influence on health, and found many studies based on the hypothesis that where a person lives can influence health (Orford, 2008). One such study conducted in Great Britain found three residential areas in Bristol with significantly higher rates of deliberate self-harm than the other areas. One of these residential areas consisted mostly of rented housing, and the other two had low SES conditions such as overcrowding (Orford, 2008). This is one example of a relationship between mental health and location.

Significant life events and past experiences are linked with depression. Onset of depression was less likely to occur after a significant life event in a study by Brown, Craig, and Harris (2008) if none of the background factors were present. This interaction may be linked with past events when the significant life event "matches" traumatic childhood experiences (Brown et al., 2008). A study of homeless women showed that significant life events are correlated with mental illness and substance abuse (Padgett, Hawkins, Abrams, & Davis, 2006). Over half the women in the study by Padgett, et al. (2006) experienced sexual trauma, and the interpersonal difficulties identified in the Brown, et al. (2008) study were primarily sexual.

There is a lot of research for within group variability within the low SES population. Research has revealed that low SES or racial minority women are more likely to experience depression, and low SES mothers are at an especially high risk (Kessler, Berglund, & Demler, 2003; Grote et al., 2007). A form of depression unique to mothers is Postpartum Depression

(PPD). Some symptoms of PPD are disrupted sleep patterns, appetite changes, severe sadness, inconsolable crying, fatigue, feelings of worthlessness, and loss of hope (Abrams & Curran, 2007). Past experience with major depression or other mental illnesses as well as other life stressors experienced by a new mother are among the risk factors for PPD (Abrams & Curran, 2007). Since low SES mothers are more likely to experience depression and people in low SES populations are more likely to experience significant life stressors, low SES mothers are a population that mental health professionals should be especially concerned with (Grote et al., 2007; Lantz, House, Mero, & Williams, 2005).

Maternal depression has negative consequences on the whole family. In mothers with PPD, somatic symptoms hinder a woman's ability to be productive inside and outside the home (Hung & Chung, 2001; Abrams & Curran, 2007). Also, maternal depression has negative consequences on the health and social functioning of children (Grote et al., 2007; McLeod & Shanahan, 1993).

There are strong links between depression and poverty in children. Significant life events, even happy ones, can place stress on a child and play a role in depression (Tracy et al. 2008). Children living in a low SES household are more likely to experience significant life events, and this raises the chances of depressive symptoms in a child living in a low SES household (Tracy et al., 2008).

Depressive symptoms in children can also be influenced by the amount of time the child is in low SES. A notable finding in the study by McLeod and Shanahan (1993) is that externalized behaviors such as antisocial behavior, hyperactivity, peer conflict or withdrawal, and headstrong behavior are correlated with "current poverty", while internalizing behaviors are associated with "persistent poverty." Internalizing behaviors have negative mental health

consequences such as symptoms of anxiety, depression, and dependency (McLeod et al., 1993). These findings indicate that it is the total amount of time in low SES that has a significant relationship with mental health (McLeod et al., 1993). Evidence that experiencing low SES in youth is correlated with depression was found in a study by Mossakowski (2008). This research found that Black and Hispanic young adults are more likely to experience low SES during childhood and more likely to experience depressive symptoms than Caucasians, so family background appears to contribute to the onset of depression in young adult racial minorities (Massakowski, 2008).

Another factor associated with depression and low SES is race. Black and Hispanic children are more likely to experience low SES in childhood than white children, and Black and Hispanic young adults have a significantly higher chance of experiencing depressive symptoms (McLeod et al., 1993; Mossakowski, 2008). A factor associated with minority status is discrimination, and there is evidence that racial discrimination has a negative impact on mental health. It is difficult to determine exactly how discrimination plays a role in depression, but discrimination perceived by a minority may increase the risk for depression (Siefert, Finlayson, Williams, Delva, & Ismail, 2007).

The social experiences of being in low SES may also contribute to depression. In a study of homeless youth, participants who felt they were being stigmatized by others internalized those experiences into negative thoughts (Kidd 2007).

While low SES is strongly associated with depression, many depressed people in a low SES population do not receive depression treatment. An explanation for this alarming problem is the presence of many types of barriers to engagement in depression treatment unique to a low SES population.

Barriers

Racial minorities and people in low SES are less likely than the general population to engage in mental health treatment, which is an alarming finding because this group is more susceptible to developing depression (Grote et al., 2007). Even if people with low SES do engage in mental health treatment, these people often do not complete depression treatment. Greeno, Anderson, Shear, and Mike (1999) found that 40-60% of people with low SES do not return to mental health services after the first visit. Low SES women not seeking care are less likely to complete a course of treatment than more advantaged people who are seeking treatment. (Miranda, Green, Krupnick, Chung, Siddique, Belin, & Revicki, 2006). The mental health of this low SES group is especially concerning; retention rates in psychotherapy were less than 20% in a study of young minority women (Miranda, Chung, Green, Krupnick, Siddique, & Revicki, 2003).

The reasons for the depressed low SES population not engaging in treatment are complex. Evidence supports that the stress of being in low SES, experiencing social problems, and dealing with persistent stressors can be a barrier to receiving treatment (Grote et al., 2007). Another reason could be due to the ineffectiveness of depression treatment for the low SES population. Racial minorities, a group that is likely to live in poverty and experience depression, may not have high treatment retention due to the cultural difference between whites and minorities. Many depression treatments are studied primarily in the white population, so treatments that are effective for the white population may not work as well for minorities (DHHS, 2001).

There are many different types of barriers that prevent low SES populations from engaging in depression treatment. Some barriers are practical, while others are psychological or

cultural. A practical barrier to treatment is a lack of education (Miranda et al. 2006; Areán et al., 2007; Ell, 2006). Lack of education can be problematic because people experiencing depression may not know that it is a diagnosable and treatable condition; they think they are just experiencing the "blues" (Miranda et al., 2006).

Stigma is a strong force preventing engagement in depression treatment in low SES populations (Grote et al., 2007; Ell, 2006). Stigma is closely related to a lack of education; people who have no education regarding depression and the treatments available may not want to engage in treatment because they have misconceptions about what a depression diagnosis means. A study of homeless women revealed two important points regarding the stigma surrounding depression within low SES populations (Luhrmann, 2008). Many homeless women refuse to utilize mental health services, and these women often feel that getting help for mental illness means admitting they are not strong enough to handle their problems on their own (Luhrmann, 2008). These women also consider a person diagnosed with a mental disorder as being "crazy" (Luhrmann, 2008). These findings are important because it shows that people within low SES populations view psychological maladjustment as being a lifetime diagnosis; they view any mental disorder as being fully incurable and a sign of weakness. Stigma within particular low SES and minority populations has also been identified. Homeless women in the study conducted by Luhrmann (2008) revealed that many homeless women refuse to utilize mental health services because they believe that would mean admitting they are not strong enough to handle their problems on their own. Low SES elders also face stigma as a barrier to treatment (Areán et al., 2007).

There are many cultural barriers that make it difficult for minorities to engage in depression treatment, and some of these differences are unique to each group (Rothe, Pumariega,

& Rogers, 2008). Stigma is a barrier that is a problem specifically for Asians, while a common barrier for Hispanics is language (Lowisohn, Ruiz, Milman, & Langrod, 1997; Gaw, 1993). A barrier that prevents Blacks from getting health care is distrust (Pumariega, Glover, Holzer, & Nguyen, 1998). Often cultural barriers refer to the difference in culture specifically between the clinician and the depressed person; these clinician-patient barriers can prevent low SES women from receiving depression treatment (Grote et al., 2007). Another type of cultural barrier is preference; minorities may prefer culture-specific treatment that is not available to them (Ell, 2006).

Treatment may also be ineffective for minorities because depression can manifest itself differently in minorities when compared to whites (Rothe et al., 2008). For example, there is evidence that the level of emotional reactivity differs between European Americans and Asian Americans suffering from depression (Chentsova-Dutton, Tsai, Chu, Rottenberg, Gross, & Gotlib, 2007). Emotional reactivity was measured by the amount of crying and feelings of sadness during a movie (Chentsova-Dutton, et al., 2007). Depressed Asian Americans had less emotional reactivity to a movie than non-depressed Asian Americans, but there was more emotional reactivity to a movie watched by depressed European Americans compared to non-depressed European Americans (Chentsova-Dutton, et al., 2007). Another example of differing manifestation was found among minority youths (Glover, Pumariega, Holzer, & Rodriquez, 1999). Minority youths, compared to white American youths, exhibit more anger and somatization (expression of psychological stress with physical symptoms) as a result of depressive symptoms (Glover, et al., 1999).

There are numerous practical barriers to treatment identified in the literature. Accessing the clinic where the treatment is offered can be difficult for a couple reasons; inconvenient

locations or transportation makes it hard to get to treatment (Areán, Gum, Tang, & Unützer, 2007; Grote et al., 2007). Another practical barrier is scheduling treatment; many people in a low SES population are overloaded and cannot find a time in their schedules to have treatment or may not be able to schedule an appointment during the hours a clinic offers treatment (Grote et al., 2007). There are many financial barriers to depression treatment among low SES populations (Areán, Gum, Tang, & Unützer, 2007). Many cannot receive treatment because they do not have insurance or other financial resources to cover the cost of treatment, and people are not able to miss work due to the lost wages (Grote et al., 2007). In addition, child care can also be a barrier to treatment, which is important to note because many depressed people in a low SES population are mothers (Post et al., 2006; Grote et al., 2007). Some additional barriers to treatment include unstable housing and complications due to having depression or some other health problem (Post et al., 2006; Grote et al., 2007; Areán, Gum, Tang, & Unützer, 2007).

Barriers to mental health services are present not only within the low SES population; there are also barriers to treatment within the health care system serving this population. Some of these barriers are systematic; mental health services sometimes do not distribute financial resources appropriately (Ell, 2006). This "discriminatory financing" has been a barrier for the elderly, and inadequate coordination of mental health care professionals also contributes to this problem (Ell, 2006). Clinical bias is a significant barrier to depression treatment (Grote et al., 2007). Clinicians are often not qualified to provide adequate care to a low SES population for reasons such as cultural insensitivity (Grote et al, 2007). This clinical bias may be a reason that distrust is a barrier to treatment (Canuso, 2007; Pumariega, Glover, Holzer, & Nguyen, 1998).

Another health care barrier is the lack of social support in psychotherapy (Areán, Gum, McCulloch, Bostrom, Gallagher-Thompson, & Thompson, 2005). This is a crucial barrier to

treatment; it is a larger problem that prevents the resolution of many other identified barriers. Developing a way to provide this social support to depressed patients would notably alter the experience of depression treatment for a depressed low SES population. As a result of the lack of social support and other barriers to depression treatment, many treatments have been developed to address the special needs of a low SES population.

Treatments

A vast amount of depression treatments have been studied, and there are many treatment strategies available that target a low SES population and address its unique needs. Some of these treatments focus on preventative strategies while others focus on treating depression in low SES populations (Frazier et al., 2007; Grote et al., 2007).

The Positive Attitudes for Learning in School (PALS) program is a community intervention developed to engage African Americans in poor urban neighborhoods (Frazier, Abdul-Adil, & Atkins, 2007). This population has an above average need for mental health services, but there is a lack of engagement (Kataoka, Zhang, & Wells, 2002). University clinicians involved in the PALS program partnered with community representatives (Frazier et al., 2007). These community representatives acted as liaisons between the clinicians and the families enrolled in PALS, and this was an attempt to break down the cultural barrier created between clinicians and low SES minority families (Frazier et al., 2007). This program had successful results: clients enrolled in PALS had an enrollment rate of 80%, compared to 55% of families referred to outpatient health clinics (Frazier, et al., 2007). After three months none of the outpatient participants were still enrolled, and after 12 months 80% of the participating families were still enrolled in PALS (Frazier et al., 2007). An obstacle in this program involved the interaction of the clinicians and community representatives (Frazier, et al., 2007). The community representatives wanted to have more input in the implementation of the program, and

they felt a conflict between working with clinicians and being loyal to their community members (Frazier et al., 2007).

Another community intervention was implemented in a Latino population (Muñoz, Huynh-Nhu, Ippen, Diaz, Uriza Jr., Soto, Mendelson, Delucchi, & Lieberman, 2006). The program, called Mamás y Bebés, had a design that would address cultural barriers in a low SES Latino culture. Although the sample size was small, there was a significant difference between the Mamás y Bebés group and the control group; more women in the control group developed PPD (Muñoz et al., 2007).

When community interventions are not available or fail to prevent the onset of depression, secondary treatment is needed. The first step in identifying a need for treatment is to diagnose a depressed individual. Areán et al. (2007) believe depression screening in primary care is a crucial tool in identifying depression in older adults. Further, it could be beneficial to implement broad screening in a low SES population.

Once an individual has been diagnosed with depression, there are many types of therapeutic interventions that can be used. One such therapy is interpersonal therapy (IPT), and the literature suggests using a brief form of IPT can be beneficial (Swartz, Frank, Shear, Thase, Fleming, & Scott, 2004; Grote et al., 2007). Brief IPT gives quick results and is more attractive to women with many stresses in their lives. The form of brief IPT explored consisted of eight weekly individual sessions lasting 45 minutes. Throughout the duration of the treatment one major issue in the participant's life is addressed, and the treatment uses techniques such as communication analysis, role-playing, and assigning homework outside the session (Grote et al., 2007). The IPT intervention has also been studied in a group setting, and group IPT was more

effective than treatment as usual in a group of low SES women with PPD (Zlotnick, Johnson, Miller, Peralstein, & Howard, 2007).

Another intervention available is cognitive behavioral therapy (CBT). Cognitive behavioral therapy teaches a depressed person to replace "disruptive irrational" thinking patterns with more constructive and "realistic" thinking patterns (Schiraldi & Brown, 2001). The intervention also helps the patient to develop a lifestyle that helps deal with mental health problems (Schiraldi et al., 2001). Whether it is applied in a group or individual setting, CBT benefits low SES women more than traditional care (Miranda, Chung, Green, Krupnick, Siddique, & Revicki, 2003).

Other social supports need to accompany depression treatment, and there is support for this in the literature; Areán et al. (2005) found that supplementing depression treatment with social supports significantly improves mental and physical functioning in the elderly. Areán et al. (2005) modified traditional CBT by combining the behavioral intervention with clinical case management (CCM). The CCM component was added because Areán et al. (2005) believe CBGT alone does not address all of the needs of low SES older adults with depression because the needs of this group are not just psychological; they also have basic needs that must be met. In Cognitive Behavioral Group Therapy (CBGT) patients underwent group treatment for six months. The three treatment modules within the therapy altered dysfunctional thinking, emphasized engagement in enjoyable activities, and addressed interpersonal relationships with assertion training (Areán et al., 2005). Clinical case management consisted of 30 minute one-on-one sessions each week to connect patients with services based on their needs identified in pre-treatment assessment (Areán et al., 2005). The combined CCM and CBGT treatment

significantly decreased depressive symptoms when assessed one year after treatment compared to either of the treatments alone (Areán et al., 2005).

Pre-treatment services are supported by the literature to be an effective way to increase the rate of engagement in mental health treatment (Dwight-Johnson, Lagomasino, Aisenberg, & Hay, 2004; Grote et al., 2007). Participants in a study by Dwight-Johnson et al. (2004) were more likely to engage in the program if pre-treatment education was provided. Also, there is evidence that using an engagement session with brief IPT helps overcome barriers to treatment, and a 45 minute engagement session is meant to be implemented at the beginning (Grote et al., 2007). This is supposed to help with barriers to treatment (Grote et al., 2007). Grote et al. (2007) use what they call an "engagement interview" to overcome many of the barriers that prevent low SES women from receiving depression treatment. The engagement interview is composed of two parts: ethnographic interviewing and motivational interviewing (Grote et al., 2007). Ethnographic interviewing is used to break down the barrier between the patient and the clinician; the patient educates the clinician about her experiences and how depression affects her as an individual (Grote et al., 2007). Motivational interviewing also allows the patient to educate the clinician about her culture and her experience with depression, and the goal of this type of interview is to motivate the patient to change (Grote et al., 2007). A comparison study revealed that participating in an engagement interview significantly increased the likelihood that a woman would engage in subsequent therapy sessions (Grote et al., 2007).

The collaboration of service providers is an intervention widely utilized to overcome barriers to treatment (Areán et al., 2005; Areán et al., 2007; Ell, 2006; Grote et al., 2007). Collaborative care treatment consists of a team of specialists: a primary care physician, a consulting psychiatrist, and a depression care specialist (Areán et al., 2007). In a study using

collaborative care, the functions of the depression care specialist were to make an assessment of the patients' mental health, educate a depressed patient about depression and the options for treatment, make a treatment plan, and coordinate the involvement of the rest of the primary care team (Areán et al., 2007). Patients were then given the option of receiving pharmacotherapy or psychotherapy (Areán et al., 2007). The results of this study were successful; a 12 month assessment found that 77% of the participants in collaborative care had received treatment compared to 53% of participants who received treatment in traditional care (Areán et al., 2007). Treatment satisfaction in collaborative care was high (72%), while about half (47%) of participants in traditional care were satisfied (Areán et al., 2007). Positive results for collaborative care were found both among poor and non-poor participants (Areán et al., 2007).

Another approach to providing additional social supports is having the therapist also function as a case manager (Grote et al., 2007). Adding a case manager component to a therapist's duties can increase the likelihood that a depressed person will engage in treatment because of the added benefits; this is positive when serving depressed expectant low SES mothers (Grote et al., 2007). When serving families with young children, mental health care providers functioning as therapists and case managers can also benefit from simply incorporating compassion and openness into their treatment (Canuso, 2007). Also, a clinician providing social services can help mothers work on skills such as time management; this type of assistance can reduce life stressors (Canuso, 2007).

Providing prolonged support for low SES depressed persons may be a needed intervention. In a study conducted by Areán et al. (2007), poor participants did not begin to benefit from collaborative care as quickly as non-poor participants. A suggestion to this problem is to offer depression treatment support for a minimum of one year (Areán et al., 2007). Long-

term monitoring through remission and maintenance phases is suggested by other researchers in the field (Ell, 2006).

Many programs attempt to overcome barriers to treatment by directly addressing practical barriers. One such program used a monetary incentive to increase retention in depression treatment among low SES African American participants (Post, Cruz, & Harman, 2006). Study participants were paid $10 after each session to help overcome practical barriers to treatment (Post et al., 2006). Thirty-four percent of participants said the monetary incentive helped, but many people had barriers that could not be fixed with money (Post et al., 2006). Also, 52% of participants stated that they attended therapy because there was a monetary incentive, even if they did not think there was any benefit to going (Post et al., 2006). Multiple programs help overcome practical barriers by helping with transportation needs, helping the patient set up appointments, and offering telephone appointments (Dwight-Johnson et al., 2004).

Depression and low SES interact with each other to create a mental health problem. Members of a low SES population do not receive the treatment needed to manage depression, and there are several reasons for this lack of engagement. Practical, medical, and cultural barriers are among the challenges that prevent the low SES population from receiving adequate mental health services, but there are many interventions that have been created to overcome barriers to engagement in depression treatment.

Discussion

The results of the literature review answer the research question presented and address the central themes identified. There is strong empirical support for the idea that high poverty rates are correlated with high depression rates. Regarding the quality of mental health care in a low SES population, many literary sources cite barriers to receiving proper mental health care,

specifically depression treatment. There are many reasons engaging in depression treatment is difficult in a low SES population, and these barriers span across several different categories. However, a wide variety of research has been done in an attempt to overcome these barriers to treatment. This finding supports the theme that community psychology can provide solutions to the problems created by low SES and depression. In addition to preventative treatments created for use in the low SES population as well as many subpopulations, there are many secondary treatments. These are designed to overcome barriers to engagement in depression treatment for people who already suffer from depression.

The results of this research have many implications for mental health care providers serving low SES populations. Many of the treatments identified in the literature seem promising, but future research should be directed at studying the long-term effectiveness of these treatments. Long term efficacy should be a crucial component when considering depression treatment for the low SES population. Solutions need to be implemented that will treat the current depressive episode as well as prevent future episodes of depression. There are many stressors associated with living in low SES, and these can contribute to the onset of depression (Tracy et al., 2008). For this reason treating the current depressive symptoms is not enough; depressed patients need to learn coping skills that will help them work through current stressors that are chronic or new stressors that will occur in the future. Efficacy of treatments may also be based on removing stressors through a social work component.

Primary care solutions in community prevention should be strongly considered in a low SES population. This approach is a proactive solution that would promote community health as opposed to treating community sickness. There are many options to how community prevention

can be implemented, and each one addresses certain barriers that are present in a low SES population.

Programs that focus on preventing depression before it occurs could have great impacts on mental health problems because programs that are family oriented have the potential to reach children early in life. This is important because of the links between depression and low SES in children (Tracy et al., 2008). Even if depression does not develop during childhood, studies show that growing up in a low SES home may be correlated with episodes of depression later in life (McLeod & Shanahan, 1993; Mossakowski, 2008). If community health programs would help children address the stresses of living in low SES early in life, there are many ways this could positively impact the children and the low SES community. Children who are able to cope better may no longer exhibit behaviors such as hyperactivity and headstrong behavior, and this would increase a child's ability to succeed in school and focus on classroom activities that improve their education. A better education and better mental health would mean a better chance that the cycle of poverty could be broken by developing the youth of the low SES population into mentally healthy and intellectually developed adults.

Given the importance of mental health early in life, programs implemented within the school system could be beneficial. Integrating the promotion of mental health into school curriculum could work like current health programs in school systems. Much like programs where kids learn the value of proper nutrition and the danger in using drugs and alcohol, mental health curriculum could teach children how damaging stress can be, what depression is, and strategies to work through stressful events and negative thoughts. In addition to preventing depression early in life, this type of program would eliminate any problems parents have scheduling time into their schedules to take advantage of mental health services.

There is value in programs such as PALS that focus on the whole family. Reaching the low SES population with this approach would allow families to engage in mental health services as a unit, and this would promote the use of family ties to work through mental health issues. Not only would engaging the whole family promote healthier family relationships, but it would also acknowledge the high value many in the low SES population place on family and a strong support system.

As demonstrated by the PALS and Mamás y Bebés programs, primary care is both effective and accepted by a low SES community. In the PALS study the community acceptance is demonstrated by the 80% enrollment rate and the high retention rate (80% of enrolled participants after twelve months) (Frazier et al., 2007). Participants in the Mamás y Bebés program were less likely to develop PPD compared to the control group, and this is an important finding because the need for secondary depression treatment could be reduced if community prevention programs reduce rates of depression (Muñoz et al., 2007). A limitation of the Mamás y Bebés program is the sample size; due to the small number of participants in this study, more research is needed with larger sample sizes to further investigate this promising solution (Muñoz et al., 2007).

There are many factors that may have contributed to the success of these programs. Several of the barriers to depression treatment in a low SES population are addressed in PALS and Mamás y Bebés. First, each program targeted a specific minority population within the low SES community. Mamás y Bebés targeted the Latino population, and PALS was designed to reach the African American population. This addresses cultural bias of a program itself; instead of being designed within a white majority, the programs are specifically geared towards minority groups. In addition to addressing the cultural barrier of race, PALS also addresses social class

barriers with the use of liaisons. These liaisons are members of the community being served, so they have the trust of the participants. They also understand the specific needs of this population and can communicate this to the clinicians.

An area of research needed is the efficacy of using one service provider compared to using a collaboration of service providers. Several articles in the literature agree that one central provider is needed, but others cite use and efficacy of collaboration. Further research should compare the benefits and costs of each type of service.

Collaborative care could be beneficial because a patient may have a diverse spectrum of needs. While a therapist is qualified to treat the psychological maladjustment associated with depression, the specialist may not have the skills needed to attend to all the needs of the patient.

It may cost more money to utilize a collaboration of service providers because not only is payment needed for the services of each provider, but there are also administrative costs associated with scheduling and executing appointments for the patient with all of the providers. Coordinating the treatment plan of the patient with several providers would also require additional resources. Collaborative care could be effective, but it would require a system where the specialists are cooperating to provide one patient the best care in the smallest amount of contact time. Not only would limiting the contact time be important to reduce the amount of resources used, but it would also be necessary to avoid creating more barriers. Many depressed patients in the low SES population have limited or inflexible schedules because they have children and do not have resources to provide alternate child care. Also, many people in a low SES population hold jobs with little job security. Both of these life situations make it difficult to get to a medical appointment, so it is even less likely that a depressed patient would be able to meet with more than one specialist. A solution to this, in addition to limiting contact time, would

be to limit the number of appointments. If it is necessary to see more than one specialist, appointments should be scheduled consecutively to avoid the hassle of coming into a clinic multiple times.

In the collaborative care described by Areán et al. (2007), collaborative care had a high retention rate and high satisfaction. These findings suggest that barriers of cost and scheduling are managed well in this program, and the program also attempts to overcome stigma and lack of education barriers by using the depression care specialist to educate the depressed patient and allowing the patient to work with the specialist to develop a treatment plan.

There are potential benefits, however, to using one service provider. As using a collaboration of providers may increase the cost, using one provider that functions in several roles can keep the costs under control. The most important function that can be added is case manager. This will give the patients assistance with fitting therapy into their schedules, and a case manager has more freedom to help patients incorporate the therapy into their everyday lives. Also, a stronger relationship can be built with a depressed person who is working with one clinician, rather than being passed on from one specialist to another. If a stronger relationship is built, the barrier of patient distrust can be eliminated. There can also be benefits to the provider, because pre-existing bias or cultural barriers can be broken down when the clinician begins to better understand the situation that has led to the depression of the patient.

It is clear that using either a collaboration of specialists or one service provider with multiple functions is a good option to increase retention and satisfaction for depressed patients in a low SES population. Giving a patient more holistic treatment could improve quality of life and decrease the likelihood of depression recurring. Also, there is potential for numerous cultural and practical barriers to be overcome by using a team or giving the therapist additional functions.

Although collaborative care seems like a good option, the findings in this research indicate that using one provider with multiple roles is the preferable option. The types of barriers preventing engagement in mental health services as well as the unique mental and social needs of a low SES depressed patient would be best addressed if there was one person coordinating care. Most importantly, cultural barriers cause patient distrust, stigma surrounding psychological maladjustment and treatment, and lack of education. Using one service provider will ensure that the patient is getting consistent and comprehensive information about depression and depression treatment; a patient may become confused when given information from different sources that may seem conflicting. Stigma and patient distrust can also be better addressed with one provider because contact time with one provider will be increased and that allows a relationship to be formed between patient and clinician. One focused relationship as opposed to several more shallow relationships should make a patient more comfortable and trusting. The patient will not only be more likely to stay engaged in treatment, but the treatment may be more effective because the patient is more likely to trust the clinician with questions and concerns relevant to the patient's mental health care needs.

An important finding in this research is that money is not the only issue. Several studies identified practical problems that are linked to a lack of resources, but giving money does not seem to help these problems. This is the conclusion based on a study using monetary incentives to increase retention rates in depression treatment (Post et al., 2006). The use of incentives does not seem to be a good solution because attendance does increase, but there is evidence this increase is no reflection of the efficacy of the treatment or the mindset during therapy (Post et al., 2006). The mindset during therapy may hinder the long term effects that can be obtained

through therapy, and more research should be conducted before considering monetary incentives as a means to engaging depressed people in treatment.

It is well-established that brief IPT as well as brief CBT are good solutions to the barriers preventing low SES depression treatment. Using abbreviated treatment overcomes a major practical barrier faced by many people of low SES seeking depression treatment. It is difficult to find time in a busy schedule to receive treatment, so reducing the number of times treatment is needed helps overcome this. Also, homework is a good solution to supplement brief therapy. This reduces the amount of contact time with the clinician, but the patient is still getting a significant amount of treatment. Homework could also help in the long term because it allows patients to incorporate treatment into their everyday lives while still having the support of their clinician.

The use of alternative therapy sessions seems to be a good solution. Telephone sessions are more convenient, but they may not be as effective because a lot can be lost without contact in person. Research focusing on this specific type of alternative therapy would more effectively assess the possible efficacy of telephone therapy. In home therapy sessions may be a positive solution, but for mothers this may have obstacles because family obligations can cause distraction. This is a significant problem for in-home therapy because single mothers are a large portion of the target population. However, alternative therapy may be a solution that would allow more people to engage in therapy; it can help overcome practical barriers such as a lack of transportation, the inability to travel due to physical disability, inconvenient clinic locations, and limited schedules.

The implications of culture and race in the relationship between low SES and depression surface often throughout the literature. Many culture-specific treatments have been developed,

and studies have attempted to overcome the barriers created by cultural differences between clinicians and people within low SES populations. The use of culture-specific treatments should be pursued. Also, clinicians need to be trained in culture-specific treatments; they need to know how to work with particular minorities and they need to know how to meet the needs of a low SES population. Some studies have addressed this, but further research in this area is needed. Not only will culture and SES awareness help to overcome distrust among depressed patients in a low SES population, but it will also reduce the incidence and impact of clinician bias.

Pre-treatment therapy is a solution that should be seriously considered for low SES populations; several articles studied the use of a pre-treatment strategy, and it has the potential to overcome multiple barriers including stigma and lack of education. Use of the pre-treatment engagement interview technique can break down the cultural barrier between clinician and patient and it can also educate the patient about depression. Breaking down these two barriers can eliminate stigma associated with depression and depression treatment. Through education a depressed person can eliminate the mindset that there is a dichotomy between being "crazy" and "normal;" misconceptions about psychological maladjustment can be corrected. Also, stigma created due to perceived clinical bias can be eliminated when the patient is allowed to educate the clinician about the patient's personal experience with depression.

The implications of this research extend beyond the low SES population. If depression is effectively prevented and treated, then overall mental health of low SES communities will increase. The results of having less depressive symptoms will be an increased ability to work and be productive, and this has implications on the micro and macro levels. On the micro level, being able to work will sustain good mental health achieved with depression treatment by positive feelings associated with working. On the macro level, increased productivity will both

contribute to society and relieve pressure on social services and government welfare programs. As a consequence of these factors, the burden that depression places on society will be released; people in higher SES populations will be able to contribute less financial and social resources to help low SES populations with financial and mental health problems.

There are limitations to this research. One major limitation is the lack of quantitative data. There was no meta-analysis or original samples obtained, and the presence of quantitative data would have made the qualitative findings stronger by showing statistical significance. Another limitation of this research is the partial amount of data gathered. Time restraints as well as financial limitations prevented this research from being more comprehensive.

Conclusion

The relationship between low socio-economic status, depression, and community psychology was explored in the course of this research. This question was addressed using three areas of focus: the relationship between low SES and depression; the relationship between factors of living in low SES and the quality of mental health care; and solutions to low SES mental health problems through the use of community psychology. This research question and the areas of focus were explored by examining existing literature.

A strong relationship was found between low SES and depression. The relationship between low SES status and depression has been well-established and thoroughly researched. There are many factors that contribute to this relationship, and it is possible that the two contribute to one another in a cyclic pattern.

Living in a low SES environment is correlated negatively with the quality of mental health care; mental health services are inadequate for the low SES population, and this population that has a high need for mental health services are less likely to engage in depression

treatment. Many barriers specific to the low SES population were found that contribute to a lack of engagement in mental health services.

The results of research in these two areas of focus highlight the need for an improvement in mental health services. In the third area of focus, solutions in community psychology were explored to find if there are effective treatments that cater specifically to the unique needs and barriers of the low SES population. The solutions reviewed include prevention programs and depression treatment. These solutions address mental health needs, but they additionally attempt to address the factors of a low SES lifestyle that contribute to depressive symptoms.

Relieving depression in the low SES population has the potential to not only improve mental health, but also relieve the financial stress on the low SES population as well as society as a whole. The implications of the research findings are important for all class levels of society; if community psychology for the prevention and treatment of depression is implemented, it can mean an overall improvement of productivity, the economy, and the mental well-being of society.

References

Abrams, L. S. & Curran, L. (2007). Not just a middle-class affliction: Crafting a social work research agenda on postpartum depression. *Health and Social Work, 32,* 289-296.

Areán, P. A., Gum, A., McCulloch, C. E., Bostrom, A., Gallagher-Thompson, D., & Thompson, L. (2005). Treatment of depression in low-income older adults. *Psychology and Aging, 20,* 601-609.

Areán, P. A., Gum, A., Tang, L., & Unützer, J. (2007). Service use and outcomes among elderly persons with low incomes being treated for depression. *Psychiatric Services, 58,* 1057-1064.

Brown, G. W., Craig, T. K. J., & Harris, T. O. (2008). Parental maltreatment and proximal risk factors using the Childhood Experience of Care & Abuse (CECA) instrument: A life-course study of adult chronic depression. *Journal of Affective Disorders, 110*, 222-233.

Bruce, M. L., Takeuchi, D. T., & Leaf, P. J. (1991). Poverty and psychiatric status: Longitudinal evidence from the New Haven Epidemiologic Catchment Area Study. *Archives of General Psychiatry, 48,* 470-474.

Canuso, R. (2007). Guiding the hands that hold the child: Supportive strategies for low-income depressed mothers and their children. *Journal of American Psychiatric Nurses Association, 13,* 304-312.

Chentsova-Dutton, Y., Tsai, J., Chu, J., Rottenberg, J., Gross, J. J., & Gotlib, I. H. (2007). Depression and emotional reactivity: Variation among Asian Americans of East Asian descent and European-Americans. *Journal of Abnormal Psychology, 166*, 776-785.

Dwight-Johnson, M., Lagomasino, I. T., Aisenberg, E., & Hay, J. (2004). Using conjoint analysis to assess depression treatment preferences among low-income Latinos. *Psychiatric Services, 55,* 934-936.

Frazier, S. L., Abdul-Adil, J., & Atkins, M. S. (2007). Can't have one without the other: Mental health providers and community parents reducing barriers to services for families in urban poverty. *Journal of Community Psychology, 35,* 435-446.

Gaw, A.C. (Ed.). (1993). Culture, *Ethnicity, and Mental Illness.* Washington, D.C.: American Psychiatric Press.

Glover, S., Pumariega, A., Holzer, C., Rodriquez, M. (1999). Anxiety symptomatology in Mexican-American adolescents. *Journal of Child and Family Studies, 8,* 47-57.

Greeno, C. G., Anderson, C. M., Shear, M. K., & Mike, G. (1999). Initial treatment engagement in a rural community mental health center. *Psychiatric Services, 50,* 1634-1636.

Grote, N. K., Zuckoff, A., Swartz, H., Bledsoe, S. E., & Geibel, S. (2007). Engaging women who are depressed and economically disadvantaged in mental health treatment. *Social Work, 52,* 295-308.

Hung, C. H., & Chung, H. H. (2001). The effects of postpartum stress and social support on postpartum women's health status. *Journal of Advanced Nursing, 36*, 676-684.

Kessler, R. C., Berglund, P., & Demler, O. (2003). The epidemiology of major depressive disorder: Results from the National Co-Morbidity Survey Replication (NCS-R). *Journal of American Medical Association, 289*, 3095-3105.

Kataoka, S., Zhang, L., & Wells, K.B. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry, 159*, 1548-1555.

Kidd, S. A. (2007). Youth homelessness and social stigma. *Journal of Youth and Adolescence, 36*, 291-299.

Lantz, P. M., House, J. S., Mero, R. P., & Williams, D. R. (2005). Stress, life events, and socioeconomic disparities in health: results from the Americans' changing lives study. *Journal of Health and Social Behavior, 46,* 274-288.

Lowisohn, J., Ruiz P., Millman, R., & Langrod, J., (Eds.). (1997). *Substance abuse: A comprehensive textbook.* 3rd ed. Baltimore: Lippincott Williams & Wilkins.

Luhrmann, T. M. (2008). "The street will drive you crazy": Why homeless psychotic women in the institutional circuit in the United States often say no to offers of help. *American Journal of Psychiatry, 165,* 15-20.

McLeod, J. D. & Shanahan, M. J. (1993). Poverty, parenting, and children's mental health. *American Sociological Review, 58,* 351-366.

Miranda, J., Chung, J. Y., Green, B. L., Krupnick, J., Siddique, J., Revicki, D. A., et al. (2003). Treating depression in predominantly low-income young minority women: A randomized controlled trial. *Journal of the American Medical Association, 290,* 57-65.

Miranda, J., Green, B. L., Krupnick, J. L., Chung, J., Siddique, J., Belin, T., & Revicki, D. (2006). One-year outcomes of a randomized clinical trial treating depression in low-income minority women. *Journal of Consulting and Clinical Psychology, 74,* 99-111.

Mossakowski, K. N. (2008). Dissecting the influence of race, ethnicity, and socioeconomic status on mental health in young adulthood. *Research on Aging, 30,* 649-671.

Muñoz, R. F., Huynh-Nhu, L., Ippen, C. G., Diaz, M. A., Uriza Jr., G. G., Soto, J., Mendelson, T., Delucchi, K., & Lieberman, A. F. (2007). Prevention of postpartum depression in

low-income women: Development of the mamás y bebés/mothers and babies course. *Cognitive and Behavioral Practice, 14,* 70-83.

Padgett, D. K., Hawkins, R. L., Abrams, C. & Davis, A. (2006). In their own words: trauma and substance abuse in the lives of formerly homeless women with serious mental illness. *American Journal of Orthopsychiatry, 76,* 461-467.

Post, E. P., Cruz, M., & Harman, J. (2006). Incentive payments for attendance at appointments for depression among low-income African Americans. *Psychiatric Services, 57,* 414-416.

Pumariega, A., Glover, S.., Holzer, C., Nguyen, N. (1998). Utilization of mental health services in a tri-ethnic sample of adolescents. *Community Mental Health Journal, 34,* 145-156.

Orford, J. (2008). *Community psychology: Challenges, controversies, and emerging consensus.* West Sussex, England: John Wiley & Sons, Ltd.

Rothe, E. M., Pumariega, A. J., & Rogers, K. M. (2008). Cultural aspects of the pharmacological treatment of depression: Factors affecting minority and immigrant youth. *Psychiatric Times, 25,* 21.

Schiraldi, G. R., & Brown, S. L. (2001). Primary prevention for mental health: Results of an exploratory cognitive-behavioral college course. *Journal of Primary Prevention, 22,* 55-67.

Siefert, K., Finlayson, T. L., Williams, D. R., Delva, J. & Ismail, A. I. (2007). Modifiable risk and protective factors for depressive symptoms in low-income African American mothers. *American Journal of Orthopsychiatry, 77,* 113-123.

Sullivan, M. (2003). The widespread effects of depression. *Word on Health,* 8.

Swartz, H. A., Frank, E., Shear, M. K., Thase, M. E., Fleming, M. A. D., & Scott, J. (2004). A pilot study of brief interpersonal psychotherapy for depression in women. *Psychiatric Services, 55*, 448-450.

Tracy, M., Zimmerman, F. J., Galea, S., McCauley, E., Stoep, A. V. (2008). What explains the relation between family poverty and childhood depressive symptoms? *Journal of Psychiatric Research, 42,* 1163-1175.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity.* A supplement to mental health: A report of the Surgeon General. Rockville, MD.

World Health Organization (2001). *Mental Health: New understanding, new hope, the world health report 2001.* WHO, Geneva. http://www.who.int/whr/2001/en/whr01_en.pdf.

Zlotnick, C., Johnson, S. L., Miller, I. W., Peralstein, T., & Howard, M. (2007). Postpartum depression in women receiving public assistance: Pilot study of an interpersonal-therapy-oriented group intervention. *American Journal of Psychiatry, 158*, 638-640.

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